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SURGEON'S CIRCULAR LETTER

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THE UNITED STATES ARMY MEDICAL DEPARTMENT ANNIVERSARY
1775 - 1950

The United States Army Medical Department will commemorate its 175th anniversary on July 27 with the realization that it has developed into the largest and best organization of its kind. From its inception until the present day, the Medical Department has steadily made progress in military medicine as well as scientific discoveries that have benefited all mankind; but it has never progressed so rapidly in both of these categories as in the past decade.

During the last war the Medical Department reached new heights in almost every field of endeavor. The saving of the lives of nearly 97 out of every 100 soldiers who were hospitalized, a low disease death rate of less than 1 to 1,000 and similarly startling figures with regard to malaria, dysentery, and other diseases which previously ravaged armies, reveal what the Medical Department accomplished.

During the post-war period, the Occupation Forces here in the Far East have been afforded splendid medical care. Because of our fine record of recoveries and freedom from disease, the stature of medical men and women has risen in the minds of all whom they have served.

GENERAL HEADQUARTERS
FAR EAST COMMAND
MEDICAL SECTION

SURGEON'S CIRCULAR LETTER

APO 500

NO. 7

1 July 1950

PART IADMINISTRATIVE

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I. Organization of the Medical Section

Departure from the Medical Section, GHQ, FEC: Lt. Colonel Harlan H. Taylor, MC, Surgical Consultant, FEC, has been appointed Chief of Surgical Services, Tokyo General Hospital.

Captain Vernon H. Loisel, MSC, Assistant Chief, Personnel Division, has completed his overseas tour of duty and returned to the ZI for reassignment.

II. Highlights of the Army Medical CorpsADMINISTRATIVE

More pay - \$100 a month in addition to prescribed pay and allowances for the rank.....

Elimination of the 32-year maximum age limit for appointment.....

Original commissions up to and including the rank of Colonel for qualified physicians.....

Transfer of all possible paper work from medical doctors to medical administrators.

Expansion and improvement of the physical facilities for training and research purposes, and for the practice of medicine.....

PROFESSIONAL

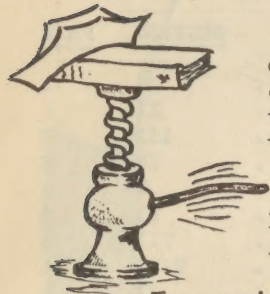
Identical standards with those of civilian medicine in the quality and quantity of graduate training.....

Army internships, civilian internships and graduate training in civilian institutions are available.

Broader opportunities for medical research with comprehensive material.....

Greater utilization of top ranking civilian physicians and surgeons as consultants and attending staff members.....

III. Age Limit for Regular Commissions Raised for Medical Women Veterans - Release from Department of Defense, Office of Public Information, Washington 25, D.C.



Many former Army and Air Force nurses, dietitians, physical therapists, and occupational therapists who served during World War II have become eligible for commissions in the Regular Army or Air Force under Public Law 514 which opens the way to them for a period of one year by increasing the maximum age requirement to 35 years plus the amount of active Federal service performed.

Under this law, enacted 16 May, all applicants honorably discharged or relieved from active duty subsequent to 12 May 1945 will be credited with service from the period of termination of duty to the date of appointment.

The provisions of the amended law apply to Reserve Nurses now on extended active duty with the Army or Air Force Nurse Corps, civilian nurses holding Reserve commissions, and former Army nurses who are not actively commissioned. Similar provisions are made for dietitians, physical therapists, and occupational therapists to obtain commissions in the Women's Medical Specialist Corps, Regular Army or Air Force. Formerly, many otherwise qualified candidates were ineligible for permanent status because of an age cut-off at 35.

Former women officers of the Army Medical Department not now on extended active duty who believe they qualify for permanent status under the terms of this legislation may apply to the Commanding General of the nearest general hospital. Those holding Air Force Reserve commissions not now on extended active duty may apply to the Director of Training, Headquarters, USAF, Washington, D.C. Those currently serving in military medical facilities should apply through appropriate command channels. Applications must be submitted during the first six months of the one-year integration period.

IV. Reclassification of Medical Corps Officers

For the guidance of Medical Corps officers who want their MOS classifications changed from a "D" to a "C" rating in accordance with the provisions of SGO Circular 43, 29 March 1948, the following is information recently received from the Surgeon General's Office in reply to such requests received in that office:

"Under the new policy an officer must have completed the formal training to meet the American Board requirements of approved residency or fellowship in a recognized teaching center or a minimum of five to nine years of professional duty limited to the specialty, Internal Medicine, for the Primary MOS C-3139.

"The policy as outlined in Circular 43, 29 March 1948, is being revised and will be distributed in the near future."

V. Estimate of Principal Health Hazards to Troops Operating in Korea

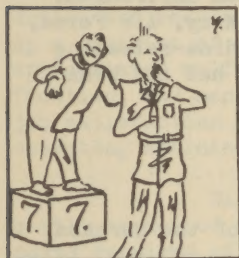
On the center page sheet of this issue is an estimate of the disease problem in Korea that may affect the health of our troops currently deployed there. This estimate is based entirely on past Army experience and reports. Medical officers concerned should be continually on the alert to recognize new problems as they arise.

VI. Item 27, Standard Form 88, "Report of Medical Examination"

In review of reports of medical examination, Standard Form 88, at GHQ, FEC, it has been noted that unnecessary entries have been made in Item 27 - Pulse Rate and Blood Pressure. Only entries under Sitting Pulse; B.P.:S D., and Sitting Pulse After Exercise: 2 Minutes after need be made as prescribed under paragraph 36 e and f, AR 40-105.

SAMPLE

2. PULSE RATE AND BLOOD PRESSURE (Arm at heart level)			
SITTING PULSE	84	B. P.: S. D.	130 . D. 72
RECURRENT: PULSE	NOT REQUIRED . D.		
STANDING (2 min.): PULSE	NOT REQUIRED	. D.	
SITTING: PULSE AFTER EXERCISE	124	: 2 MIN. AFTER	88

VII. Seven Medical Courses Set

The Surgeon General's Office has announced that seven Medical Department courses will open in July, August and September. One will be for Army nurses, four for enlisted personnel, and two for both officers and enlisted personnel.

The 24-week nurses' course, in Operating Room Technique and Management, will be conducted in selected Army hospitals. Applicants must have had at least four months' graduate operating room experience. Only Regular Army or Reserve nurses on extended active duty with at least one year of service remaining after completion of the course are eligible.

The two courses open to both commissioned and enlisted personnel are the medical equipment maintenance and optician courses. They will be given at the St. Louis Medical Depot, beginning 1 September. The course in medical equipment maintenance has been lengthened from 32 weeks to 44 weeks. The optician course will be for 26 weeks.

The maintenance course is available to Regular Army Medical Service Corps officers and warrant officers who have had military or civilian experience in mechanical, electrical or radio repair. An enlisted applicant must be qualified as a medical equipment mechanic, x-ray technician, electrical repairman, or radio repairman. Those accepted will be trained in the supervision, installation, inspection and repair of all electro-mechanical medical equipment used by the Armed Forces.

For the optician course, MSC officers must be Regular Army or Active Reserve with at least one year of service remaining after completion of the course. Civilian experience as a qualified optician is desirable. Selected officers will be taught to supervise a fixed, mobile or portable optical installation and to maintain Medical Department optical equipment. Enlisted personnel will receive training in grinding, cutting, polishing and edging lenses; fitting, adjusting and repairing spectacles, and repairing technical equipment used. Training in refraction is not included.

Four courses for enlisted personnel only will be given at the Medical Field Service School, Brooke Army Medical Center, Fort Sam Houston, Tex. The eight-week electro-encephalography course is open only to qualified medical technicians below grade E-6.

The eight-week course in sanitary technician procedure course is limited to those below grade E-4. Experience in insect control, food inspection, medical laboratory or treatment, or public health is desirable.

The elementary psychiatric social work course will run 16 weeks. It is open to qualified neuropsychiatric or personnel management technicians. Training or experience in sociology or psychology is desirable.

The 12-week neuropsychiatric class will be composed of personnel below grade E-5. Applicants must be qualified medical or surgical technicians, to be enrolled in such a course.

VIII. Scientists Develop New Type Water Disinfectant

An iodine compound has been used successfully by a joint Army-Navy research team to disinfect drinking water in canteen quantities.

The controlled research study, conducted during the past six months among military personnel and natives on Majuro Atoll, Marshall Islands, indicated that compounds releasing free iodine in concentrations of eight parts per 1,000,000 were highly effective disinfecting agents and did not produce ill effects among water users.

Majuro was chosen as the test site because toxic effects of polluted water are more readily apparent under tropical conditions. All service personnel and natives there, totalling about 220 persons, participated in the research.

In addition, one group of 24 underwent thorough clinical and laboratory study, while a second group of 16 served as a control unit by drinking only water treated with chlorine.

At the conclusion of the study, the Committee on Sanitary Engineering and Environment of the Division of Medical Sciences, National Research Council, recommended to the Army, Air Force, and Navy Surgeons General that the military departments adopt and standardize an iodine-releasing compound for individual disinfection of drinking water. As yet the iodine compound has not been made available for issue.

IX. Report on Operation "Management"* - 1st Lt. James W. Keenan, MSC, Office of the Surgeon, Military District of Washington

In the fall of 1948, the Surgeon General, Department of the Army, set up in the Medical Plans and Operations Division of his office, a Management Research Group. This management group was given the primary duty of setting up a management plan for all medical facilities within the Department of the Army. The problem of introducing managerial concepts was the aim of achieving economical and efficient operations while still maintaining the high level of professional standards. This management group, under the leadership of Col. A. L. Tynes, MC, and Col. F. H. Gibbs, MSC, of the Plans and Operations Division, Surgeon General's Office, and with technical supervision by Lt. Col. George Schunior, a management engineer, established a pilot installation at Valley

Forge General Hospital in Phoenixville, Penna., which was to be utilized as a testing station for the development of hospital managerial plans.

Under the guidance of the management group of the Surgeon General's Office a plan was evolved to reorganize Valley Forge General Hospital under an organization which would allow for the free use and practical application of many of the managerial concepts that have been so successfully applied to industrial enterprises in the United States. In the spring of 1950, the experiment at Valley Forge General Hospital was interrupted with the planned reduction in the overall hospital program which necessitated the closing of Valley Forge Hospital. In order to insure that the successful efforts that had been put forward in the establishment of a new administrative set-up for general hospitals would not be lost, it was decided to bring in representative administrative officers from all the general hospitals and army area surgeon's offices to indoctrinate them in the management methods that had worked practicably at Valley Forge and could be applied to other medical installations.

In order to indoctrinate these officers, a specially designed course in management methods was originated at Valley Forge General Hospital. The course was mainly designed to introduce the concept of management with its corresponding ideas of increased efficiency and low unit operating cost which is another way of describing the present watchword of "economy" within the Armed Forces.

The Surgeon General early in June 1949 designated Valley Forge General Hospital to be the "pilot" installation for the introduction of the new plan for the organization of General Hospitals. The overall results of this experiment were to reveal that Army hospitals, if properly organized and managed on an administrative basis, can reduce costs and increase operational efficiency at no

* Published in the May 1950 issue of the MONTHLY HEALTH REPORT, Military District of Washington.

loss in the present high degree of professional care now rendered. The proposed new organization for General Hospitals placed into practical operation at Valley Forge is contained in the revised (proposed) Special Regulations SR 40-590 (this regulation is in its final stages of approval by the Department of the Army).

At the present time, a "task force" from the Management Section of the Surgeon General's Office is in the process of developing a management plan for the administration of Station Hospitals. For this experiment, the Surgeon General has designated Fort Meade Station Hospital as the field installation.

The overall proposal for reorganization of the hospitals contains nothing that may be considered as a radically new idea but rather reflects the present-day thinking and practical application of the successful ideas of both civilian and military hospital administrators. The management crew of the Surgeon General's Office has merely taken the principles of sound management developed by American industry and applied them to the problems of military medicine. For example, they utilized the management principle of "grouping like things together" and reduced the present-day general hospital organizational set-up from a hodge-podge of scattered divisions and partial responsibilities to a consolidation of six well integrated units with clearly defined duties and responsibilities. Using the same principle of "grouping like things together" they set up a position of Hospital Treasurer in which one officer has custodial responsibility for all non-appropriated welfare funds. They have used the management tools of: space utilization, work simplification, and manpower control to the advantage of making for better working conditions, greater job satisfaction and the elimination of over-staffing; all resulting ultimately in an increased operating efficiency at lower unit costs.

With the introduction of machine records, they have eliminated the detailed and costly burden of maintaining stock records, accounting for cost, and complying with a myriad of reports required of field installations. Along with the machine records, they are developing a Cost Accounting System that will make for easy costs comparison among Army medical installations. In conjunction with the Food Service program they have designated trained Hospital Dietitians to assume the responsibility of Food Service Supervisors. These and many more management ideas have been successfully applied towards the goal of increased efficiency in hospital administration with a reflected decrease in costs per patient day.

It is difficult to definitely appraise in monetary savings nor is it presently possible to apply a standard "yardstick" to accurately determine the amount of increased efficiency of the overall results of the Valley Forge experiment; primarily, because the program, per se, has not yet had time to fully develop. However, it can be said with certainty that this program has a field of unlimited possibilities within the frame work of our present antiquated hospital administrative organization.

The success of any management program depends upon the mature application of the known and proven tools of management towards the ultimate goal of better patient care through better hospital management.

X. Red Cross and Ward Nurses - Captain Irene McIntyre*, ANC



The Ward Team in the Army Hospital consists of the doctor, the nurse, the social worker, the ward man, members of the Physical Department and any other person concerned with the care of the patient. Each of these team members accepts the following three-fold aim in the performance of his duties:

1. The care and welfare of the patient;
2. The return of the patient to duty or his normal mode of living; or
3. The return of the patient to a changed mode of living due to his illness.

Despite this common aim, sometimes there has been a lack of understanding between ward nurses and Red Cross social workers. This has been manifested in discussions with individuals and groups.

* The late Captain McIntyre served as Chief Nurse at the 22d Station Hospital, FEC, from 1946 - 1948. Her death occurred in the fall of 1949 after several months of illness at the Walter Reed General Hospital.

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In an attempt to seek some of the reasons, questionnaires were submitted for the purpose of getting a broad sampling of opinion from nurses and Red Cross Social Workers.

From a total of 46 answers from nurses, both Army and civilian, the following information was tabulated:

- 25 knew the name of the social worker assigned to her ward
- 21 did not know the name of the social worker assigned to her ward
- 14 discussed routinely her patients with the social worker
- 32 did not discuss routinely her patients with the social worker
- 35 when on duty, knew when the social worker was on her ward working with patients
- 11 when on duty, did not know when the social worker was on her ward
- 27 conferred with the social worker about patients
- 19 did not confer with the social worker about patients
- 42 referred cases to the social worker
- 4 did not refer cases to the social worker
- 30 could outline in a general way the duties of the social worker
- 16 could not outline in a general way the duties of the social worker
- 46 considered it important to have mutual understanding

The following suggestions were made by the nurses for improving relationships:

- 3 suggested that a list of the duties of the social worker be made available for the general information of the ward nurses
- 4 suggested that the duties and responsibilities of the social worker be presented in a lecture to groups of nurses
- 1 wanted the social worker to be available for ward rounds weekly
- 3 felt that social intermingling of the two groups would lead to better understanding
- 2 suggested that the social worker always announce her presence on the ward to the nurse
- 1 wanted conferences with the social worker so that she might know the results of her work with the patient
- 1 felt that more chief nurse, supervisor, social worker contact was necessary. It was felt that there was at present no understanding of each other's work.
- 1 suggested that conferences between ward nurse and social worker be arranged at a convenient time. This nurse felt that they were too busy at the time the social worker made her visits to stop for conference.
- 2 asked that Red Cross social workers be represented at nurses' meetings where it would be possible to discuss mutual problems
- 1 nurse stated that the social worker often asked to talk to the ward officer and by-passed her completely. She felt "left out of things."
- 1 felt there should be more clarification of the social worker's place as a member of the "health team."
- 1 suggested full time workers for gastro-intestinal, tuberculosis and cardiac wards. She felt these services presented a heavy load of social problems.

From a total of 20 answers from Red Cross social workers representing Army hospitals from 250 to 2500 beds, the following information was tabulated:

- 20 stated that they made themselves known to the nurse in charge of the ward
- 8 discussed routinely their patients on the ward with the nurse on duty
- 12 did not discuss routinely their patients with the nurse on duty
- 13 made their presence on the ward known to the nurse on duty
- 7 did not make their presence on the ward known to the nurse on duty
- 17 conferred with the nurse on duty to obtain information about patients
- 3 did not confer with the nurse on duty to obtain information about patients
- 19 could outline in a general way the duties of the ward nurse
- 1 could not outline in a general way the duties of the ward nurse
- 1 felt that nurses should be informed that the social service office is always open for discussion of patient problems
- 1 wanted the nurse to be informed about the community resources available for patients through Red Cross, so that she might have a better understanding of care for the patient after discharge
- 2 felt that the nurses should be represented at their meetings and that the social worker should attend the nurses' meetings

- 2 suggested better referral policies. It was felt that the nurse was not always alert to the patient who needed social service and that many times the patient had to wait until the social worker appeared on the ward before he could make contact with her
- 5 suggested routine conferences between the ward officer, ward nurse and social service worker to discuss the planned treatment for individual patients
- 2 suggested more orientation in the Nurses' Basic course in the duties and place of the Red Cross social service worker in the Army Hospital
- 1 felt that all new social workers should meet the Chief Nurse and confer with her on occasion regarding their ward work

From this tabulation, it is evident that some place along the line we have failed in stressing the joint responsibilities of the nurse and the social worker in the complete care of the patient.

Our problem at present is to fill the gaps which exist in the programs of both the nurse and the Red Cross social worker. We must emphasize the need of teamwork.

"Teamwork" is defined by Webster as "work done by a number of associates usually each doing a clearly defined portion, but all subordinating personal prominence to the efficiency of the whole." Teamwork in the care of the hospital patient is created through the mutual understanding of all persons offering specialized services to the patient.

"To cure the body it is necessary to have a knowledge of the whole of things" is an aphorism attributed to Hippocrates. For many years hospital patients were treated by the doctors and nurses and were considered adequately cared for. We realize today that this type of care is only part of our responsibility toward the patient. In practically every civilian hospital of any size or standing, the medical social worker has become an important part of the staff.

During the past war, the presence of Red Cross social workers in our Military hospitals proved to be of untold value both by giving additional care to patients through their various services, and by relieving the doctors and nurses of many time-consuming patient problems.

The social worker can bring to the other members of the team the information she has gained in her interviews with the patient regarding his background, his family, his attitude toward his disease, his previous work, interests, achievements. She knows the patient sociologically and emotionally and is in a position to give the nurse a far broader picture of the patient as a person.

It is the social worker who sees the troubled, over-anxious patient or his family group, and with the skill acquired by her special training, can discern the social factors which influence his illness. She is an indispensable asset to proper diagnosis of patients' ills.

The nurse, on the other hand, has more frequent contact with the patient. In her bedside nursing duties she often exemplifies the "Mother" and many times is the recipient of confidences which she can put to good use if she possesses the broad vision of the necessity for complete care of the patient.

Because the nurse is so often busy with routine duties, she does not have the contact with the social workers one would wish for. It must be admitted there are a few who, due to complete misunderstanding, resent intrusion on their territory. This attitude is fast disappearing and as a better understanding is developed between the two groups, one will welcome the presence of the other and there will be an exchange of pertinent information which will lead to better care of the patient.

There are several methods which might be instituted to bring about this needed understanding. It must be borne in mind that there are no short cuts to thoughtful, long-range planning to bring about effective teamwork.

In this study, a nurse has presented the point of view of the nurses to the Red Cross social workers. A social worker in turn has spoken of her work at the head nurses' meeting. This type of interchange of information could be carried on in any type military hospital and should be encouraged.

The social worker should be called upon to participate in the educational program for nurses. She should contribute to the case studies presented and be present to interpret her duties.

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New nurses, civilian and Army, need orientation to the part played by the social worker in each hospital. New Red Cross social workers should receive similar orientation to nurses' duties.

All too often in the large hospital the Red Cross social worker never meets the Chief Nurse officially. This is an unfortunate situation since the Chief Nurse is often one of the strong sources of support for the social worker.

Staff conferences on the ward, to include the ward officer, the nurse, and the social worker, will enable each member of the team to make his particular contribution in developing the plan for the individual patient.

Frequent informal conference between the nurse and the social worker is probably the best means of promoting interest on the part of each and allows for an exchange of information concerning the patient.

It is hoped that this discussion can be used by the nursing and Red Cross Social Service staffs in the various Army hospitals as a basis for further study and possible improvement in the relationship between these two groups.

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1. American Red Cross Handbook
2. Journal of Social Case Work, April 1949; December 1946
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4. Nursing For the Future, Esther Lucille Brown, PhD; Russell Sage Foundation, 1948
5. Patients Have Families, Henry B. Richardson, M.D., F.A.C.P., New York, 1945
6. The Elements of Research, Whitney; Prentiss-Hall, New York, 1946, Revised Ed.
7. The Methodology of Educational Research, Good, Barr & Scates; Appleton-Century Co., New York & London, 1941
8. The Patient as a Person, G. Canby Robinson, M.D., L.L.D., Sc.D.; The Commonwealth Fund, New York, 1946
9. The Rehabilitation of the Patient, Caroline H. Ellidge; J. B. Lippincott Co., 1948

XI. Medical Service of an Infantry Division - Lt Col P. C. Sheldon, MC, 25th Inf Div, APO 25

(Medical personnel consists of: O-99; W.O.-2; EM-999; Total-1100)



Division Surgeon's Office (O-4; EM-5) is composed of the Division Surgeon, Division Medical Inspector, Division Neuropsychiatrist and a Medical Assistant. The division surgeon is a member of the special staff of the division and exercises technical supervision of the medical service and medical training for the division.

The Medical Battalion (O-46; WO-2; EM-293) performs the second echelon of medical service. Second echelon medical service consists of evacuating casualties from dispensaries, battalion aid stations and regimental collecting stations to the clearing stations where the casualties receive treatment and are prepared for evacuation by the third echelon or returned to duty.

The mission of Headquarters & Headquarters Company (O-27 (DC-18); WO-2; EM-72) is the command, administration and organizational maintenance of the Medical Battalion; division medical supply and division dental service.

The mission of the Ambulance Company (O-4; EM-86) is primarily that of transport; that is, the evacuation of sick and wounded from regimental collecting stations and certain aid stations back to the division clearing stations.

The mission of the Clearing Company (O-15; EM-135) is to receive, sort and furnish temporary medical and surgical care for patients until evacuated to the rear; provide definitive treatment and care for patients with minor illnesses, wounds and injuries. The clearing company is capable of operating three clearing stations, each of which may operate independently with regimental combat teams.

The Regimental Medical Company (O-13; EM-201) provides first echelon medical service for an infantry regiment including emergency treatment, collection, serving and evacuation of patients

during combat, and dispensary care.

The company headquarters (O-5; EM-34) has the responsibility of administration of the unit. The commanding officer serves on the staff of the regimental commander.

The collecting platoon (O-4; EM-62) has the following functions: Evacuates casualties from the aid stations operated by the battalion medical platoon; establishes and operates a regimental collecting station for casualties requiring treatment while enroute to the rear; provides medical service to regimental headquarters, headquarters and headquarters company, service company, tank company and heavy mortar company; reinforces the battalion medical platoons with litter bearers and cross-country ambulances (jeeps).

The Medical Detachment (O-7; EM-63) of the Division Artillery, consists of a headquarters and five battalion detachments. The noncombat functions of the medical detachment consists of operating dispensaries for emergency treatment and care of the sick and injured. In combat, its functions are administration of emergency medical treatment on the battlefield, the removal of casualties from the field to aid stations, and establishment and operation of aid stations for the collection, sorting, temporary care and emergency treatment of casualties.

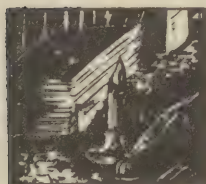
The Medical Detachment (O-2; EM-22) of Division Engineer Combat Battalion consists mainly of two functional groups, the company aid men and aid station personnel. The medical service of the battalion operates in a fashion similar to that of other medical detachments.

The Medical Detachment, Division Headquarters (O-1, EM-13) provides first echelon medical service for division headquarters troops. The detachment supplies aid men to the reconnaissance platoons and to the signal company. The detachment establishes and operates an aid station in the rear echelon of division headquarters.

XII. Initial Distribution of Training Film - TF - 8-1639

Initial distribution of Training Film 8-1639, "Medical Supply - The Armed Forces" (running time, 24 minutes) is being made to installations in the Far East Command.

XIII. Recent Department of the Army and FEC Publications



AR 35-1355, 1 May 50 - Disability Retirement and Severance Pay
 AR 70-140, 5 May 50 - Insect and Rodent Control
 AR 40-507, 8 May 50 - Standards for Medicinal Agents
 AR 145-120, 8 May 50, C-1 - Physical Standards and Examinations
 AR 40-20, 12 May 50, C-2 - Army Nurse Corps - General Provisions

AR 145-8, 24 May 50 - Joint Army - Air Force Agreement Relative to ROTC Units of MD
 AR 40-615, 26 May 50 - Pharmacy Management
 AR 145-490, 29 May 50 - Admission and Treatment of Members in Medical Treatment Facilities of the DA
 SR 40-225-21, 10 Mar 50 - Yellow Fever Immunization Requirements - Pakistan
 SR 40-530-50, 6 Apr 50 - Herniated Nucleus Pulposus (Treatment and Disposition of Patients)
 SR 140-120-1, 13 Apr 50 - ORC - Immunization
 SR 40-590-10, 2 May 50 - Hospital Fund Limitations
 SR 40-590-48, 5 May 50 - Report of Treatment of Pay Patients
 SR 600-37-1, 5 May 50, C-1 - Women's Army Uniform
 SR 40-1080-10, 15 May 50 - Reporting of Bed Capacity and Status Data by Fixed Medical Treatment Facilities
 SR 600-450-1, 23 May 50, C-1 - Physical Evaluation; Hospitalization; Disposition; Separation for Physical Reasons

(Continued on page 12)

1. This estimate of disease problems is based on the past experiences of U. S. Forces in Korea and on the reported occurrence of disease and sanitary conditions in the Korean population.

2. Previous experience shows the total hospital admissions for disease among U. S. Forces in Korea to have been in general comparable to those in Japan but considerably higher than for the total Far East Command. Respiratory infections, including those of streptococcal nature, can be expected to be at least as high as in Japan. In fact, outbreaks of streptococcal infections with high succeeding incidence of rheumatic fever have been experienced by American troops in Korea. The diseases considered to present special immediate and potential hazards are discussed briefly below:

a. Diarrhea and dysentery. The intestinal tract infections are considered to be among the most important of those diseases which may affect American troops. Past experience has shown their incidence to have been the highest in the Far East Command. Contributing significantly to this situation are the high endemicity of these conditions among Koreans and the unsatisfactory sanitary practices by the Koreans. Strict sanitary discipline will be required for the prevention and control of these infections as well as the utmost care in water purification and mess management. Native food handlers should not be used.

b. Malaria. Malaria is an extremely important potential health hazard. It is highly endemic among the native population, and what little control there has been exerted will now be totally lacking. In addition, under present conditions mosquito breeding can be expected to increase sharply and the chances for transmission of disease to be markedly enhanced. Strict malaria discipline, both by units and individuals, will be required. Drug suppression will in all likelihood be indicated. The malaria season extends in general from April through October.

c. Smallpox. A highly virulent form of smallpox has been endemic and epidemic in Korea at intervals during the past several years. There were large outbreaks in 1946 and again 1948. (A large number of cases occurred among American personnel stationed in Korea in 1946.) Strict attention to satisfactory smallpox vaccination will be required.

d. Cholera. An outbreak of more than 15,000 cases of this disease occurred among Koreans in 1946. No appreciable numbers have been reported since that time and none since late in 1947. This disease then must be considered as a latent potential hazard. U. S. troops now in the Far East Command have received basic series of cholera vaccinations. Stimulating doses will be required in the event of the appearance of the disease in the area. Prevention of cholera, like that of the other enteric infections, however, must rest primarily with the application of proper sanitary practices.

e. Typhoid Fever. Typhoid fever is highly endemic among the Koreans. Attention to vaccination and sanitary practices are required for its prevention among the American troops.

f. Typhus Fever. This louse-borne disease occurs sporadically among the Koreans. Typhus vaccination, as practiced for all troops in Japan (and Korea), the application of de-lousing procedures when indicated, and personal hygiene and sanitary discipline are the applicable preventive measures.

g. Japanese B encephalitis. This disease has been reported from Korea and several cases have occurred in Americans there in the past. Mosquito control and discipline and Japanese B encephalitis vaccination are the measures indicated for its prevention.

h. Venereal Disease. The venereal infections are prevalent in Korea and the problem of infection of American troops is comparable to that in Japan and Okinawa.

3. The following is a table showing the incidence (per thousand per annum) of total diseases, diarrhea and dysentery, and malaria among American Forces in Korea in 1947, 1948 and June 1949, the last month of American occupation in Korea. These are compared to similar data for troops in Japan and the entire Far East Command for the same periods. It is pointed out that admissions shown in this table are from troops engaged in normal occupation activities.

Incidence of Communicable Diseases Among American Troops

	All Diseases	Diarrheas and Dysentery	Total Malaria
1947			
Korea	817	20	8.3
Japan	853	6.5	1.6
FEC	727	13	15
1948			
Korea	655	31	19
Japan	666	3.5	1.6
FEC	540	12	9.7
June 1949			
Korea	547	12	98
Japan	547	1.8	14
FEC	487	2.4	14

RESTRICTED

SR 40-590-49, 26 May 50 - Admission and Treatment of Civilian Employees of Cost-Plus-A-Fixed-Fee Contractors of DA in Medical Treatment Facilities of Department Outside Continental United States

T/O&E 8-580, 21 Apr 50 - Evacuation Hospital

T/O&E 8-650, 31 Apr 50 - Medical General Laboratory

GHQ FEC CIR 24, 11 May 50 - Hospital Funds

GHQ FEC CIR 26, 18 May 50 - Venereal Disease Control

GHQ FEC CIR 27, 2 Jun 50 - Food Inspection by the Veterinary Service, United States Army

GHQ FEC CIR 29, 8 Jun 50 - Medical and Dental Supplies of Narcotics, Alcohols and Precious Metals

PART II

TECHNICAL

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XIV. New Cures for Seasickness



Compounds which are said to be as effective as dramamine in preventing seasickness have been discovered through tests made possible by Army and Air Force cooperation.

According to a preliminary report, research studies indicate that benadryl, hyoscine, and artane have properties which nullify motion sickness. These drugs were tried by approximately 1,000 troops aboard the Army transport General Maurice Rose, sailing between New York and Bremerhaven, Germany. Different groups of volunteers were used on each leg of the trip.

Benadryl, similar in composition to dramamine, was used earlier in the treatment of allergies, such as hay fever and hives. The antihistaminic properties of this and several other drugs formed the basis of tests made to determine whether they were also useful in preventing seasickness.

Researchers reported that the preventive and curative actions produced during the experiments are not related to antihistaminic properties. In addition, it was found that benadryl and dramamine, though useful in preventing seasickness, are not considered suitable for use by air crew personnel because of their sleep-inducing qualities.

Hyoscine, which has been used for years to prevent motion sickness, does not produce as much drowsiness as benadryl, but it causes unfavorable reactions such as dryness of the mouth and occasional blurring of vision. It is one of the drugs being procured as part of the national stockpile program.

Used with moderate success in treatment of cerebral palsy, artane was tested aboard the transport and found to have some usefulness in blocking seasickness. It is similar in action to hyoscine and produces the same undesirable side reactions.

XV. Diarrheal Diseases

The following article by Major Arvey C. Sanders, MSC, 406th Medical General Laboratory, Tokyo, Japan, is on the laboratory procedures for the diagnosis of diarrheal diseases. This article is particularly timely and application of the procedures recommended of particular importance because enteric infections tend to increase in incidence during the summer months. In addition, in Japan, dysentery, chiefly bacillary in nature, continues to occur with a high incidence and there is a real

possibility of increasing occurrence of these infections among occupation personnel.

The diarrheal diseases including acute bacterial food poisoning, the so-called common diarrheas and dysentery, both bacillary and amebic are spread through contaminated food and water. A break in mess sanitation is quite frequently the precipitating event. Person to person transmission of these infections particularly those caused by organisms of the Shigella and Salmonella groups are however not uncommon. Missed cases and convalescent carriers can be important foci from which numerous other cases arise without the apparent assistance of intermediate vehicles such as food and water. Early specific diagnosis, segregation and adequate treatment of these infections then is extremely important both in the interest of shortening the course of the illness and for the prevention of spread of the disease to others. Mild cases of diarrhea should not be overlooked in this regard since they are frequently the source of secondary cases which may be considerably more severe.

XVI. Recommended Laboratory Methods for Use in Diarrheal Diseases - Major Arvey C. Sanders, MSC, 406th Medical General Laboratory, Tokyo, Japan



In view of the ever present likelihood of outbreak of cases of food poisoning due to Salmonella and the sporadic occurrence of scattered cases resembling mild Shigellosis, the following suggestions are offered to aid in the laboratory diagnosis of enteric infections.

An indication of the possible bacillary nature of dysentery may often be found by examining a wet mount of fresh stool. The presence of an inflammatory exudate consisting of large numbers of polymorphonuclear leukocytes is almost always associated with a Salmonella or Shigella infection. Whenever possible fresh fecal material or rectal swabs should be incubated directly to fresh MacConkey and SS agar plates. For dispensary use it is recommended that a buffered glycerol-saline solution be inoculated with about 1 gm of fresh feces. If direct collection of a fecal specimen is not feasible a rectal swab should be taken and the distal half of the applicator broken off and immersed in the glycerol-saline solution. Such specimens should be forwarded expeditiously to the nearest Station Hospital Laboratory where the inoculum should be streaked on MacConkey or SS agar plates, at the same time inoculating heavily a tube of Selenite-F enrichment medium. Following 18 to 24 hours incubation at 37°C the Selenite-F inoculum is streaked on to fresh MacConkey or SS agar plates, and this in turn incubated 18 to 24 hours.

The inoculation of Selenite-F enrichment medium increases the possibility of isolating members of the genus Salmonella (including S. typhosa) but does not increase the yield of Shigella organisms. No holding or enrichment medium can improve on the isolation of the latter type organisms over that obtained from fresh stool. However, Selenite-F will often serve as a fair holding medium for Shigella, and positive isolates may be obtained in about 75% of instances when this method is used.

From the original plates and from those streaked from Selenite-F, colorless (non-lactose fermenting) colonies are transferred to paired tubes of Kligler's Iron Agar (by streak and stab) and the latter medium incubated 18 to 24 hours. Those tubes which show an alkaline (red) slant and an acid (yellow) butt with or without gas bubble formation or blackening of the media are highly suggestive of enteric pathogens. The duplicate tube in all such instances should be forwarded immediately to the 406th Laboratory. If adequate bacteriologic facilities exist, further identification should continue from the other tube of such medium at the Hospital Laboratory.

The 406th Laboratory is prepared to expeditiously handle all such suspicious enteric specimens and can usually return a telephonic report, if desired, within 24 hours of receipt of the Kligler tube. Any organisms isolated and identified locally as enteric pathogens should subsequently be forwarded to the 406th Laboratory for definitive typing and identification. SS agar is suitable for such submission.

Addenda:

All media referred to are Difco products listed in the Medical Supply Catalogue as follows:

(1) MacConkey	1-258-750
(2) SS agar	1-452-800
(3) Selenite-F	1-403-200
(5) Kligler's Iron Agar	1-241-700

The formula for buffered glycerol-saline (4) solution is given below:

Glycerine - Saline Solution

2.5 mg. dibasic sodium phosphate (Na_2HPO_4)
 0.6 gm Monobasic sodium phosphate (NaH_2PO_4)
 1000 ml. physiological saline (0.85%)
 4 ml. phenol red (0.2%)
 1 ml. formalin 1:10,000
 Dissolve glycerine in water
 Adjust reaction to pH 8
 Add 4 ml. of 0.2% phenol-red
 Add formalin
 Dispense in 10-12 ml. amounts in 1 oz. screw capped bottles
 Sterilize at 15 lbs / 20 min. with caps screwed loosely.
 Tighten caps. Invert in refrigerator overnight to check for leaky caps.
 On standing the glycerol may slowly decompose and render the mixture acid. In such a case the solution turns yellow and should be discarded.

XVII. Treatment of Poisoning By Barbituric Acid Derivatives - Colonel Francis W. Pruitt, MC,
 Medical Consultant, GHQ, FEC



easy to carry out.

Cases of varying degree of severity of barbital poisoning have been encountered from time to time in this command. Generally they are only mild and respond to ordinary nervous system stimulants. Occasionally, however, cases are encountered in which the individual has ingested large amounts of one of the barbital compounds. The plans of therapeutic management vary with the individual physician and the stimulant used. The following regime, which is in use at the Tokyo General Hospital, is considered practical and thorough in cases of poisoning due to the barbituric acid drugs. We have found this plan useful and

METHOD OF TREATMENT

A standard method of treatment of barbiturate poisoning was established and followed in all cases in the Tokyo General Hospital. This consisted of certain preliminary procedures common to all groups, followed by coramine and picrotoxin.

Routine Treatment:

1. A history was taken and physical examination was done, and an attempt made to identify the drug ingested. Whenever possible the prescription numbers were checked and the drug established. Members of the family were sent for to determine the amount of the drug in the patient's possession, if known.
2. In all cases the stomach was aspirated with a large bore rubber tube, and washed with four to five liters of tap water, the organ being left empty. The washings are saved and sent either to the hospital laboratory or to the 406th Medical General Laboratory. The patients were then catheterized and the urine also sent for toxicological examination. (In all cases included in this report, barbiturates were found either in the stomach contents or urine, or both.)
3. An intravenous infusion of glucose and saline was started. Plasma was given to those in shock. The patient was put in a mild Trendelenberg position.

4. An airway was inserted where needed.

5. Bronchoscopy was done immediately wherever aspiration of food was suspected.

6. Frequent aspirations of the nasopharynx were done in comatose cases to maintain an unobstructed airway.

7. a. Coramine Therapy. 10 cc. of 25% coramine intravenously stat, followed by 5 cc. every 5 minutes for the first hour. Thereafter, intravenous drip, allowing 5 cc. per hour. In profound cases, booster doses of 5 cc. every 15 or 30 minutes may be added as indicated. This therapy to continue until patient responds to stimuli. We have used up to 60 cc. of coramine intravenously in the first two hours.

b. Picrotoxin Therapy in conjunction with Coramine Therapy. A test dose of 3 mgm. given intravenously stat. If no response, the 3 mgm. dose is to be repeated every 5 minutes for 3 doses, allowing 15 minutes to elapse, and another series of 3 injections at 5 minute intervals. Therapy is to be continued in this cyclic manner until the return of reflexes or spontaneous motion. Sodium amytal should be on hand to treat convulsions.

The following table based on the degree of severity may be useful:

<u>Grade</u>	<u>Conscious</u>	<u>Tendon Reflex</u>	<u>Corneal Reflex</u>	<u>Swallowing Reflex</u>	<u>Pupils</u>	<u>Coma</u>
1	Yes	Yes	Yes	Yes	Normal	No
2	Semi	Yes	Yes	Yes	Constrict	No
3	No	Absent	Yes	Absent	Pinpoint	Yes
4	No	Absent	Absent (*)	Absent	Pinpoint	Deep

(*) The most important differential of a grade 3 from a grade 4 is the loss of the corneal reflex. This was found to be a sign of a poor prognosis.

REFERENCE:

Watts, Joseph C., and Ruthberg, Jack: Coramine (nikethamide) in barbiturate poisoning: comparison with picrotoxin: preliminary report, Annals of Internal Medicine, 1948, xxix, 1104.

XVIII. Leprosy (The Forgotten Disease?) - 1st Lt. Genevieve A. Connors, ANC, 35th Station Hospital, APO 25



"It is strange that men should see sublime inspiration in the ruins of an old church and see none in the ruins of a man." Chesterton.

Leprosy according to Webster is defined as a skin disease characterized by ulcers and white scaly scabs; by medical books it is described as a systemic infectious disease characterized by a prolonged incubation and a chronic course in which dermal manifestations predominate in some cases and neural changes in others.

The history of leprosy dates back as far as that of man. The disease was a common one in England and on the continent during the early and middle ages but it gradually subsided in the 14th and 15th centuries. At present it exists in various parts of the world. Iceland contains the greatest numbers of lepers in proportion to the total population although the disease is seen in Russia, Japan, China, Mexico, Central and South America. It is also prevalent in Africa, India, and the Philippines. In the United States there are lepers in California, New York and the gulf states.

Leprosy is not a tropical disease. However, it does become more of a problem in the tropics with the more intimate family grouping, crowding, intermarriage, undernourishment and lack of sanitation.

That leprosy is rare is as mistaken an idea as that it is a tropical disease. It has been said that one of every 500 of the world's population is a leper.

ETIOLOGY: The Mycobacterium leprae, commonly called M-leprae may be demonstrated from lesions of the infected person. The skin and nasal mucous membranes are believed to be the most likely portals of entry. The mode of transmission still remains somewhat of a mystery in spite of the number of M-leprae which may be found in the lesion and the ease with which it is demonstrated. Certain facts are evident and worthy of mention.

- (1) It is not hereditary; it is absent in the fetus and in case of twins one may contract the disease after birth while the other may remain free.
- (2) A high immunity occurs in adults. No worker among lepers has been infected if ordinary precautions of simple antiseptic technic were observed and intimate contact with the patient avoided.
- (3) Children are particularly susceptible and it was only after children were immediately separated from their leprous parents did the high rate in the Philippines subside.
- (4) There has been no evidence that leprosy is carried by animal or insect and all attempts to transmit the disease by such vectors to man and animal have been unsuccessful.

And now comes the question -- "How does leprosy work in the body?" It affects one or both of two areas - the skin and the nerve fibers, when it is principally in the skin, lumps called nodules appear and may become open ulcers. When it is affecting the nerve fibers the nerves are killed. At first there may be pain, then loss of feeling and finally the loss of bones and flesh which wither away when there are no nerves to vitalize them. The M-leprae has entered the body and it may incubate for two years or for as long as thirty years. The lesions appear to be due to the actual presence of the M-leprae and areas most affected are the face, extremities, nasal membranes, nerve trunks, - lump nodes and the testicles. The three types of skin lesions produced are the macular, the tuberculoid and lepromatous. The victim may suffer physically from fever and from recurrent local pains while the nerves are being attacked as well as suffering mental agony from being crippled, disfigured, blinded and an outcast of society, sometimes being treated as less than human. The onset of the disease is slow and the two cardinal symptoms are dyesthesia and skin lesions. Other symptoms in the early stage are indefinite and include malaise lassitude depression. Anesthesia may be the only symptoms for months or even years. Enlargement of superficial lymph nodes, loss of sweating and loss of hair in affected areas as the eyebrows and legs, ulceration of the nasal septum, contractures of the extremities, loss of digits are very common.

Now after knowing this - what can we as nurses do to help these patients and what treatment can be given? An ample well-balanced diet and hygienic surroundings are probably more effective than any drug. Chaulmoogra oil and its derivatives have long been used. First it was given intramuscularly - subcutaneously and also injected into the lesions. The most recent experience has been with the use of promin and diazone - the results have been encouraging. Leprosariums have been founded with several in the Philippines, Honolulu and our own at Carville, La. In the leprosarium the patients are segregated into groups which are ambulatory, who care for themselves and report to the clinic for treatment, the remainder are hospital patients and unable to do much for themselves. In both cases care should be given to isolation, disinfection and sterilization of equipment and material used by the patient. Exercise, cleanliness, surgical dressings for local eruptions help. Quite as important as the physical treatment is the building up of the morale and the lessening of the patient's mental distress. For years a victim had no home, the world had no place for him; even his family deserted him. This, in itself, has prevented many patients from reporting for treatment or to have their illness diagnosed. Death due to leprosy occurs very seldom but complications chiefly those of the heart and kidney - pneumonia, gangrene and tuberculosis may account for a large percentage of deaths. Therefore in treating these hospital patients such measures as forcing fluids, recording intake and output, cool sponges for high temperatures - sedatives for pain and restlessness - proper elimination, occupational therapy, all add to the patient's comfort. For the most part the nursing care for a leper in the hospital will depend largely upon his complications and the nurse will find it necessary to use every bit of nursing skill and knowledge that she has ever learned.

CAN LEPROSY BE CURED? The world's greatest leprologists prefer to use the term "arrested" or symptom free rather than announce a definite cure. Thousands of cases have been greatly relieved and hundreds have been restored to apparently complete health. When the laboratory results are negative the disease is considered arrested and the patient may be released, but there is a high percentage of relapses.

In the Philippine Islands the experience has been that 50% of the arrested cases coming to autopsy are lab positive. America's leprosarium is located at Carville, Louisiana. Carville is located on the east banks of the Mississippi, 75 miles from New Orleans. It is an institution of the USPHS set aside wholly for the care and treatment of persons afflicted with leprosy or suffering from its effects. It is estimated by eminent leprologists that there are 5,000 cases of leprosy in these United States and only 400 are residents at Carville, among whom are a number of war veterans (married). The wives live outside the hospital and can visit from 7 a.m. - 7 p.m., daily.

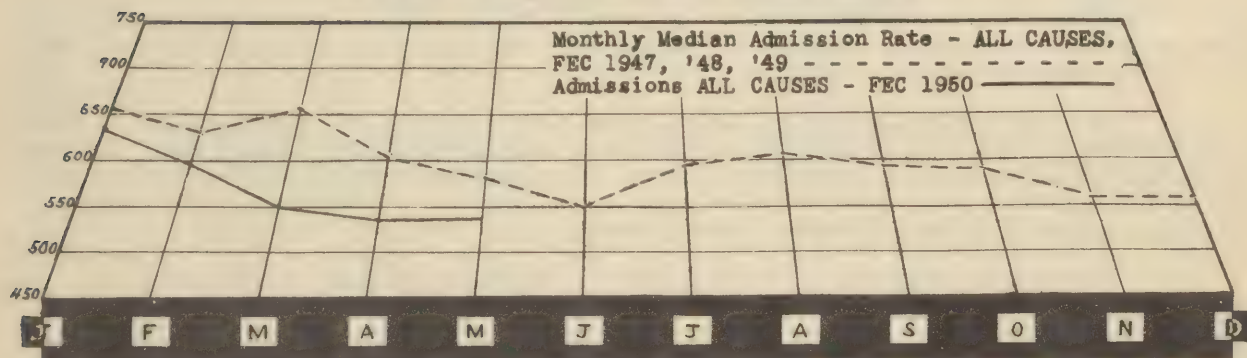
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3. Father Damien of Molokai, by Ann Roos
4. Who Walks Alone, by Perry Burgess

PART III

STATISTICAL

HEALTH OF THE COMMAND



Admission rates per 1000 troops per annum for the four-week period ending 26 May 1950 were as follows:

	<u>FEC</u>	<u>JAPAN</u>	<u>MARBO</u>	<u>PHILCOM(AF)</u>	<u>RYCOM</u>
All Causes	534	564	274	336	558
Diseases	472	501	207	297	493
Injuries	62	63	67	38	64
Psychiatric	8.1	8.6	2.9	1.7	10
Common Respiratory Diseases and Influenza	47	53	22	21	32
Primary Atypical Pneumonia	.71	.81	0	0	.73
Common Diarrhea	2.3	1.8	0	1.7	6.6

RESTRICTED

	<u>FEC</u>	<u>JAPAN</u>	<u>MARBO</u>	<u>PHILCOM(AF)</u>	<u>RYCOM</u>
Bacillary Dysentery	.18	0	0	0	1.5
Amebic Dysentery	.35	0	0	1.7	2.2
Malaria, new	.35	.12	0	5.2	0
Infectious Hepatitis	5.8	6.7	0	10	1.5
Mycotic Dermatoses	1.9	1.4	0	0	6.6
Rheumatic Fever	.18	.23	0	0	0
Venereal Diseases	146	159	23	72	151

In May, the rate of admission to hospitals and quarters for all causes for Army and Air Force personnel of the Far East Command was 534 cases per thousand strength per year. This represents an increase in the rate of 2 over the previous month. The non-battle injury rate increased from 51 in April to 62 in May. Only twice since 1947 has the rate been as high as 62. The all diseases component, 472, of the total rate is an unprecedented low for the Far East Command. Of interest among the major commands is the fact that in Japan a slow but constant decrease in the all causes admission rate has been experienced since the inception of the Far East Command. Although a marked increase in non-battle injuries admissions was reported in Japan for May, the all causes rates as well as all diseases rates were the lowest so far recorded. RYCOM, to the contrary, has experienced a rather constant increase in admissions for all causes since its activation, and now has about the same rate as Japan. Of the reportable diseases, RYCOM's increased rate is accounted for in part by its increased venereal diseases rate over the past several months. MARBO and PHILCOM(AF) have had a more static admission rate than the above.

The average daily non-effective rate for all causes for May was the same as the preceding month -- 15. This is considered very favorable when compared to the ZI and other overseas commands. The injury component of the total non-effective rate is 2.7 per 1000 per day. Venereal diseases non-effective rate for this month was 0.14 which means that on an average day in May, less than 21 troops, including both Army and Air Force, were non-effective from venereal diseases.

DISEASES:

Common Respiratory Diseases and Influenza: The decrease in common respiratory diseases and influenza incidence for May depicts the seasonal expectation and presented a rate of 47 for the month as compared to 60 for April.

Malaria: Four new cases of malaria were reported in the Far East Command for this month, three of which were from PHILCOM(AF) and one from Japan, giving a FEC rate of .35. Although this is an increase of 3 cases over the month before, it compares favorably with the same periods in 1947, 1948 and 1949 at which time the rates were 13, 5.9 and 6.3, respectively. RYCOM again, for the fourth consecutive month, reported no new cases.

Diarrhea and Dysentery: The incidence of intestinal diseases infections in the Far East Command has remained unusually low for the year. The increased incidence in these diseases among Japanese during the previous months has as yet had no apparent effect on military personnel. The rate decreased from 4 in April to 2.8 for May. In May of 1948 and 1949, the incidence of these diseases gave rates of 10 and 3.7 respectively for the Far East Command. In the major commands, RYCOM's rate of 10 was the highest; PHILCOM (AF) 3.5; Japan 1.3 and MARBO, 0.

Poliomyelitis: Through May of this year, 7 cases of poliomyelitis have been reported among occupation personnel, 5 of which occurred in PHILCOM(AF) and 2 in Japan. In comparison, through May of 1948, 14 cases were reported and in 1949, 15 cases. To date, this year, no deaths have been reported; neither were any reported in 1949 for the same period; 2 occurred in 1948 during this period.

Venereal Diseases: The total venereal diseases rate of 146 for May remained about the same as it was in April -- 147. The white troops component thereof decreased from 144 to 139, and the colored increased from 169 to 198. The total venereal diseases rate for the major commands likewise remained static for the past two months.

Non-Battle Injuries and Deaths: A marked increase in non-battle injuries admissions during May increased the rate per thousand per annum from 51 in April to 62. Since August of 1947, the rate has been this high only twice, October 1948 and May 1949. The increase in injury admissions is attributed, at least in part, to the increased outdoor activity among troops, and may be

considered as a seasonal expectation. There were 46 deaths reported during the month of May, 6 of which resulted from diseases and 40 from injuries. As will be noted, this is a greater number of deaths than is normally expected during a four-week period for the Far East Command. The number resulting from diseases is about as expected. The number resulting from injuries is much greater than usual and is due chiefly to the number of fatalities resulting in the C-54 crash in the Tanzawa Mountain range on 21 April 1950.

Evacuation:

Tabulated below are the number of patients evacuated from the major commands to the ZI during the four report weeks in May and the number of patients awaiting evacuation as of 26 May 1950:



	BY AIR	BY WATER	TOTAL	PNTS AWAIT EVAC
JAPAN	155	20	175	88
MARBO	14	0	14	4
PHILCOM(AF)	8	9	17	1
RYCOM	55	16	71	22
FEC	232	45	277	115

Evacuations of military personnel per thousand strength for the period of 29 April to 26 May were as follows:

JAPAN	1.4	PHILCOM(AF)	1.3
MARBO	1.5	RYCOM	3.7
FEC	1.7		

Hospitalization:

The bed status as of 26 May 1950 was as follows:

	Normal Bed Capacity*	Operating Beds*	Beds Occupied
JAPAN	3,939	1,869	1,515
MARBO	200	200	94
PHILCOM(AF)	1,919	693	454
RYCOM	750	413	210
FEC	6,808	3,175	2,273

The percent of normal bed capacity and operating beds occupied as of 26 May 1950 was as follows:

	Percent Normal Bed Capacity Occupied	Percent of Operating Beds Occupied
JAPAN	38	81
MARBO	47	47
PHILCOM(AF)	24	66
RYCOM	28	51
FEC	33	72

FINAL PHYSICAL EXAMINATION

The following messageform from the Department of the Army concerning physical examination for officers being released from active duty is published for information and guidance:

"1. Experience during the recent officer strength reduction program indicates that there has been difficulty in effecting the prompt separation of Officers because of the discovery of physical defects during the final physical examination required 72 hours prior to separation.

"2. In order to facilitate timely separation of officers upon expiration of their categories, the requirements of paragraph 6a, AR 40-100 and Section II, SR 135-175-5 will be waived and final type physical examinations will be given not earlier than ninety (90) days nor later than sixty (60) days in advance of the separation date of the following groups of officers:

a. Officers who cannot remain on active duty beyond current category because of age in grade.

b. Officers whose requests for a new category have been finally disapproved by the Department of the Army.

c. Officers who do not apply for a new category.

"3. Final type physical examinations (Standard Form 88) will be accomplished and forwarded with the application for relief from active duty or tender of resignation of the following:

a. Officers requesting release from active duty under the provisions of paragraph 3, SR 135-175-4.

b. Officers requesting release from active duty under the provisions of paragraph 4, SR 135-175-4.

c. Officers requesting release from active duty under the provisions of paragraph 6, SR 135-175-4.

d. Officers who tender their resignation from the service under the provisions of paragraph 2, 3 and 4, AR 605-275 (see paragraph 5c (4), AR 605-275).

"4. Completed Standard Form 88 (Report of Medical Examination) will be transmitted in duplicate direct to The Adjutant General, Attn: AGPO-S-C, by the examining installation.

"5. Pending publication of amendment to SR 135-175-4, paragraph 5b thereof is amended to require physical examination not earlier than ninety (90) nor later than sixty (60) days prior to the month in which relief from active duty is to be effected.

"6. Upon separation officers will be requested to sign a statement as follows: "There has been no change in my physical condition since my last final type physical examination on _____ (date), with the following exceptions:" If exceptions are noted, officer will be re-examined prior to separation. Statement will be forwarded with the officer's field 201 file to the Department of the Army."

CHLOROQUINE, DRUG OF CHOICE FOR SUPPRESSION AND TREATMENT OF MALARIA

Chloroquine diphosphate has been shown to be the drug of choice for the suppression and treatment of malaria. This drug is less toxic than atabrine when given in proper doses and produces more rapid symptomatic relief when used for treatment. The drug is colorless and produces no discoloration of the skin. Objectionable side effects have been few and none have been cause for concern. Pruritis without rash has been the only symptom observed with any significant frequency and this is reported to occur in less than 10 percent of treated patients. Other symptoms noted rarely have been anorexia, mild nausea and vertigo.

While not a true prophylactic, chloroquine has been shown to be very effective in the suppression of malaria. When used for this purpose, the dose is one half (0.5) gram once a week. When conditions warrant this procedure, a definite schedule indicating a specific day of the week on which the drug is to be given should be established and maintained. It is emphasized that the use of suppressive medication does not obviate the necessity for strict malaria discipline, both by units and individuals, or for the application of procedures for mosquito control.

When used for treatment of clinical malaria, the dosage schedule recommended is as follows: Initial dose upon confirmation of the diagnosis, one (1.0) gram, followed in six hours by one half (0.5) gram, then one half (0.5) gram daily for each of two successive days. This is a total of two and a half (2.5) grams in three days.

Chloroquine diphosphate, a standard medical item, is listed in the Armed Services Catalog of Medical Materiel under Stock No. 1-139-300, Chloroquine-diphosphate Tablets, 0.5 gm. (7½ gr.), 1000s: Equivalent to 0.3 gm. of base.

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The Chief Surgeon extends an invitation to all personnel of the Medical Department to prepare and forward, with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted. Copy should be forwarded so as to reach the Medical Section, GHQ, FEC, not later than the 10th of the month preceding the issue in which publishing is desired.

Major Vincent I. Hack, Editor